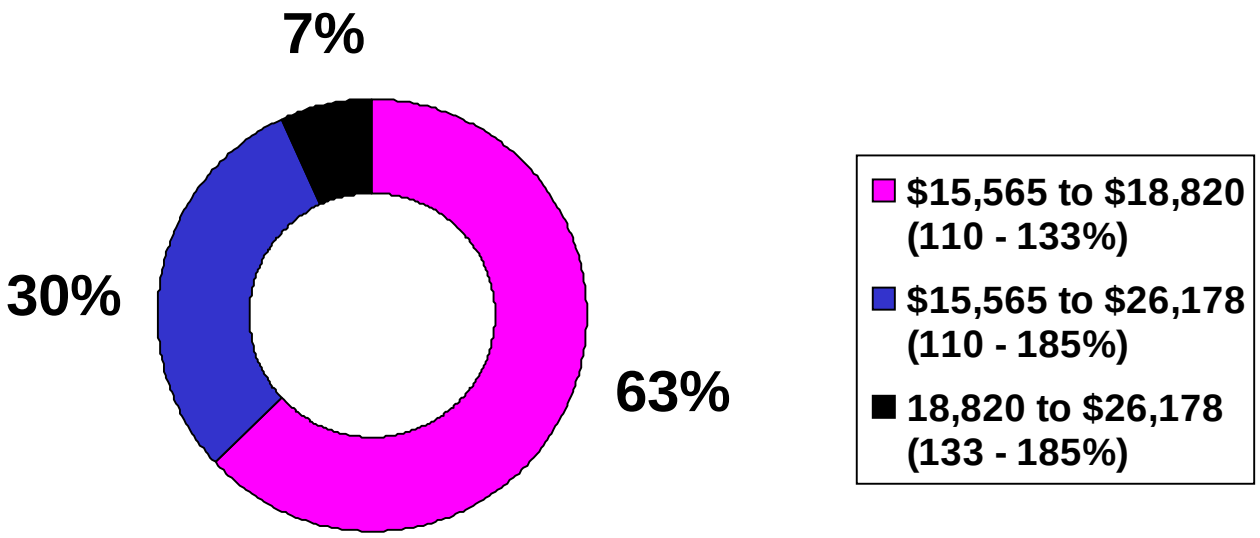
RIte Care Expansion

8/94	Original RIte Care Waiver	1. Uninsured Pregnant/Postpartum women 185-250% FPL 2. Children under age 6 to 250% FPL 3. Uninsured Pregnant Postpartum women 250-350% FPL
5/96	Six & Seven Year Olds	4. Children ages 6 and 7 250% FPL
5/97	Welfare Reform: FIP and 8 to 18 Year Olds	5. Children ages 8 and 18 250% FPL 6. Parent eligible for FIP cash assistance, previously ineligible for AFDC (no AFDC deprivation factor)
1/97	Home-Based Child Care	7. Home-Based Day Care Providers and dependents allowed to enroll in RIte Care
6/98	Extended MA lengthened to 18 months	8. Extended MA families (in effect parents. Since children would be eligible otherwise)
11/98	Low Income Parents	9. Parents of MA-eligible children, up to 185% FPL
1/99	Center Based Child Care Providers	10. Center Based Child Care Providers (subsidized coverage)
10/99	Alien Children	11. All children up to 250% FPL, without regard to alienage
10/99	18 year olds	12. Children age 18 covered to 19th birthday
11/00	Foster Children	13. Foster children enrollment in RIte Care begins

Distribution of Family Income of Low Income Parents Expansion Group

(Eligible via Section 1931)

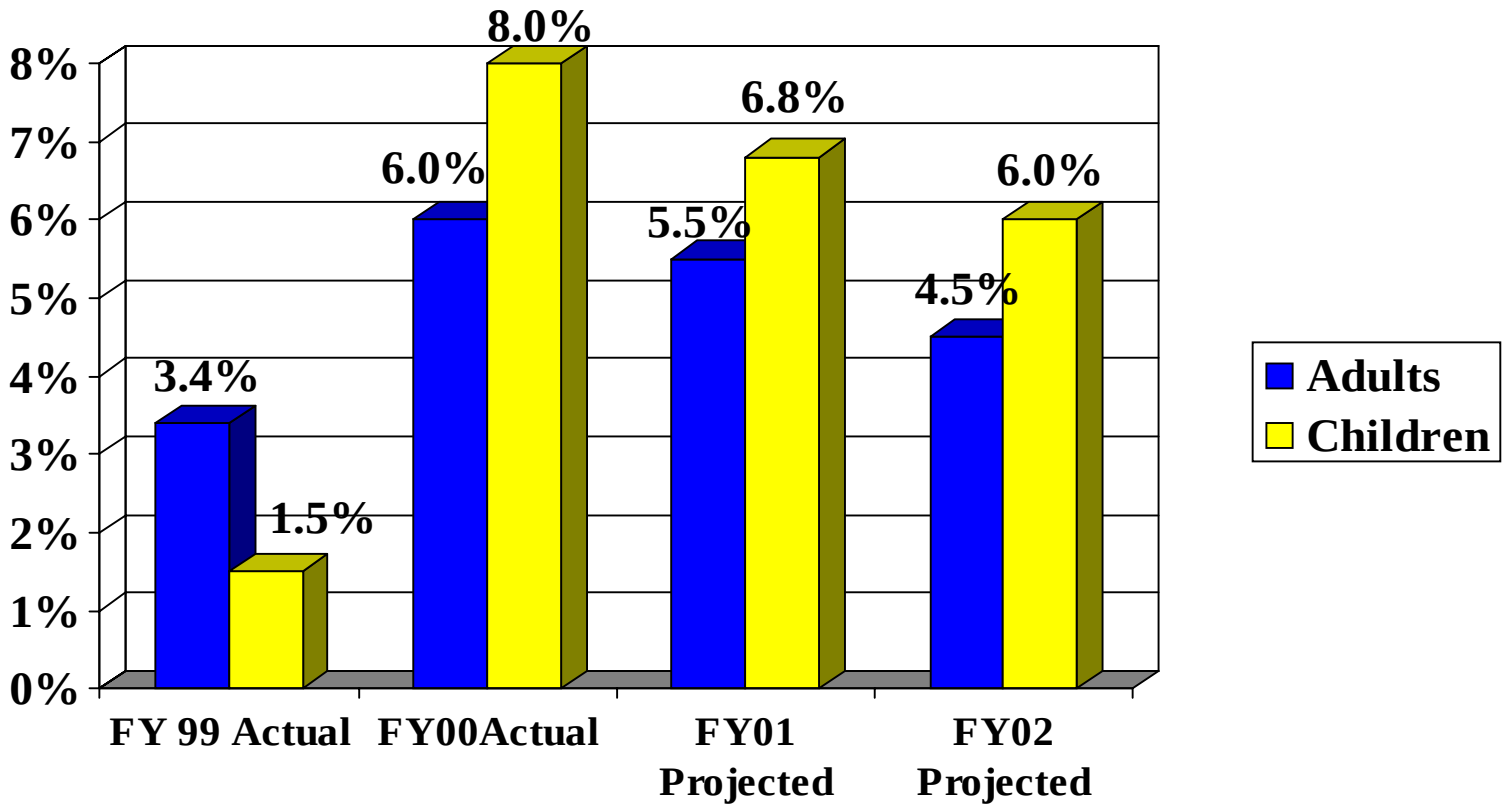


* FIP income limits vary independently of the Federal Poverty Level. However, a family of three with one earner with gross earned income up to approximately 110% of the FPL could obtain cash assistance.

** The Federal Poverty Level is $14,150 annually for a family of three (the median family size in Rite Care).

Rhode Island - Average Annual Growth in the Disabled Medicaid Population

Percent change from Prior Year



Note: SSI Children only

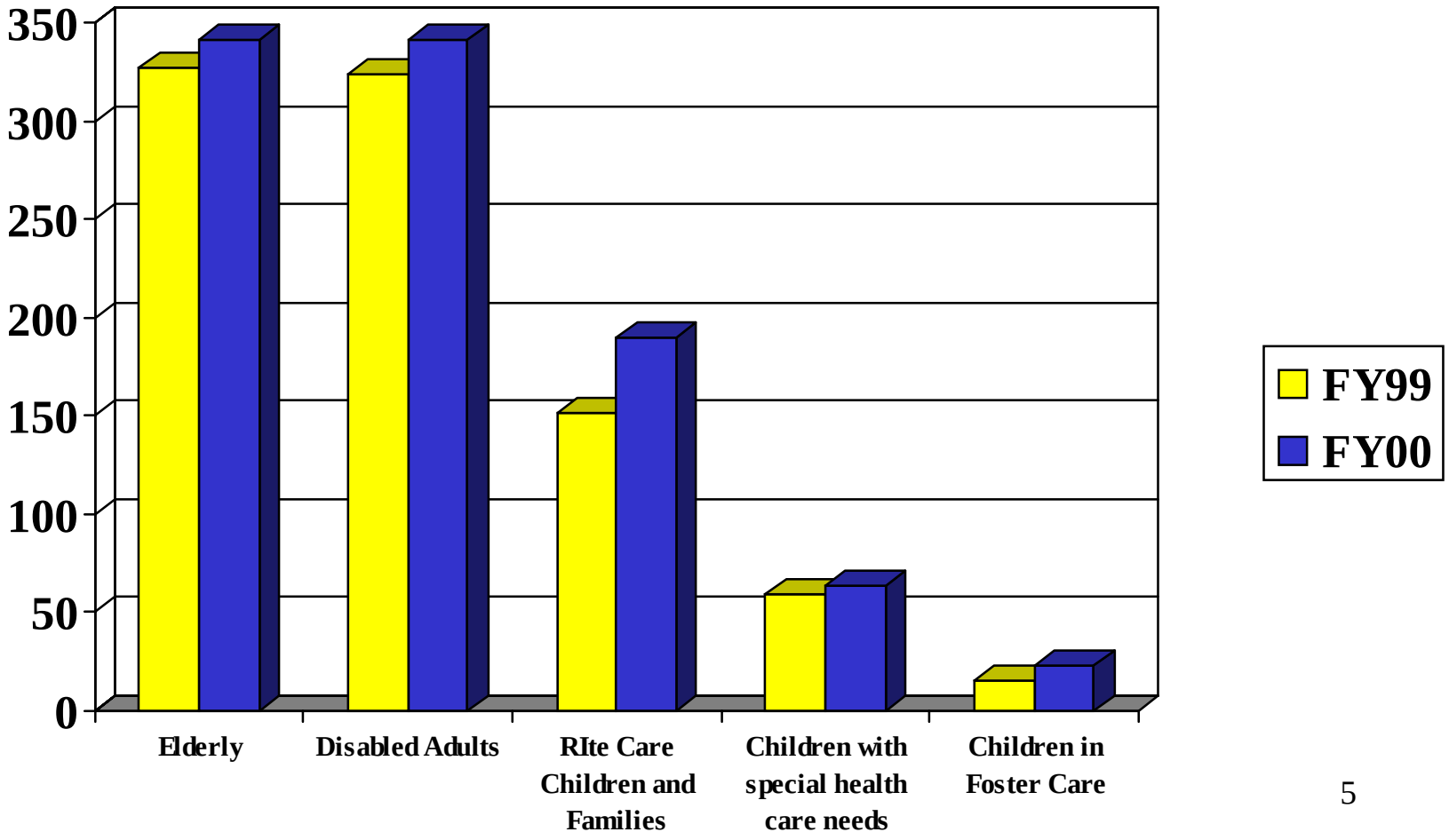
History of RI Statewide Medicaid Expenditures

Percent Change from Prior Year

FY 2002 DHS Adjusted General Revenue Growth = 8.0%

Fiscal Year	Rhode Island	United States
1997	7.8 %	11.2 %
1998	4.0 %	5.9 %
1999	7.6 %	6.1 %
2000	12.5 %	7.1 %
2001	18.0 %	6.6 %
2002	4.2 %	7.7 %

RI Medicaid Expenditures by Population, FY99 & FY00



Major Trends SFY 01 – SFY 02
RI Medical Assistance Program

- Elderly represents 12% of caseload and 38% of expenditures.
- Adults with Disabilities represents 14% of caseload and 22% of expenditures.
- Children and Families represents 74% of caseload and 40% of expenditures.

Major Trends SFY 01 – SFY 02
RI Medical Assistance Program

Dually Eligible Population-Eligible for both Medicare and Medicaid

- Approximately 25,000 persons:
- Representing 14% of Medicare caseload and 31% of Medicare costs.
- Representing 18% of Medicaid population and over 55% of Medicaid costs.

Drivers of Medicaid Expenditures

- Increasing pharmaceutical prices and utilization – at 16 percent per year.
- Increasing managed care enrollment - estimated at 21 percent over two years.
- Increasing enrollment for Children with Special Health Care Needs-estimated at 13 percent over two years.

Drivers of Medicaid Expenditures

- 1.34 percentage point decrease in FMAP from 53.79 to 52.45.
- 14% annual increases for behavioral and rehabilitative services for SSI Children.
- Increasing enrollment for Children with Special Health Care Needs estimated at 13.0 percent over two years

Drivers of Medicaid Expenditures: Dual Eligible Population

- RI is experiencing double digit growth in home health services, which appears to be driven by substitution from the recent loss of services from Medicare.
- Medicaid Home Health Services are increasing by over 25% in the current year
- Medicare Part B premium increased (10% Jan 01).
- Decreasing demand for Medicaid nursing home days by approximately 1.5% per year.

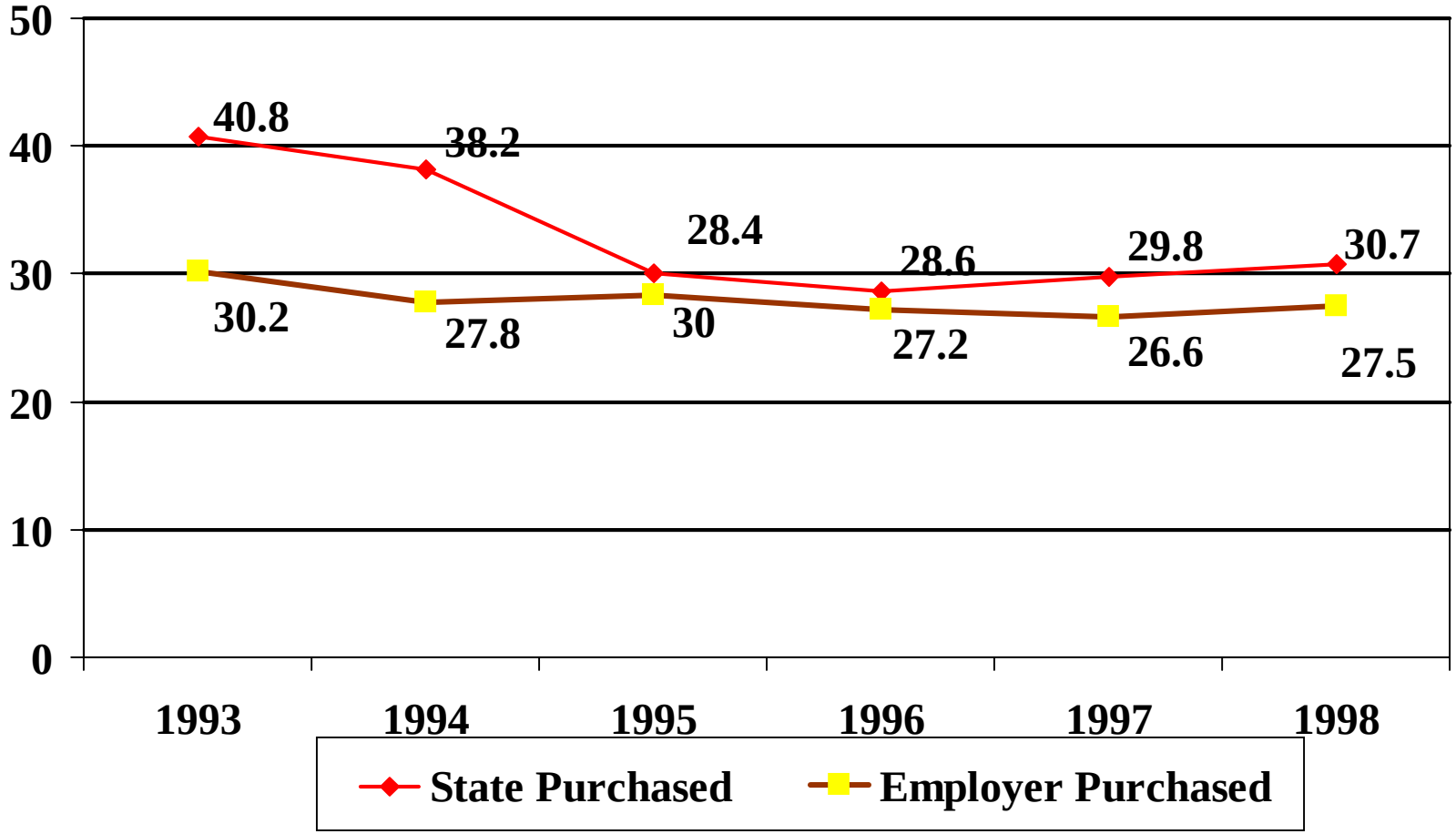
Drivers of Medicaid Expenditures: Capacity Issues of Epic Proportions

- CNA shortage in hospitals & nursing homes.
- Reimbursement levels not keeping up with private health insurance and Medicare reimbursement.
- Physicians fed up with dealing with insurers and government.
- Utilization has shifted from hospitals and ER to primary care settings.

Lessons Learned: Outcomes-Health Status

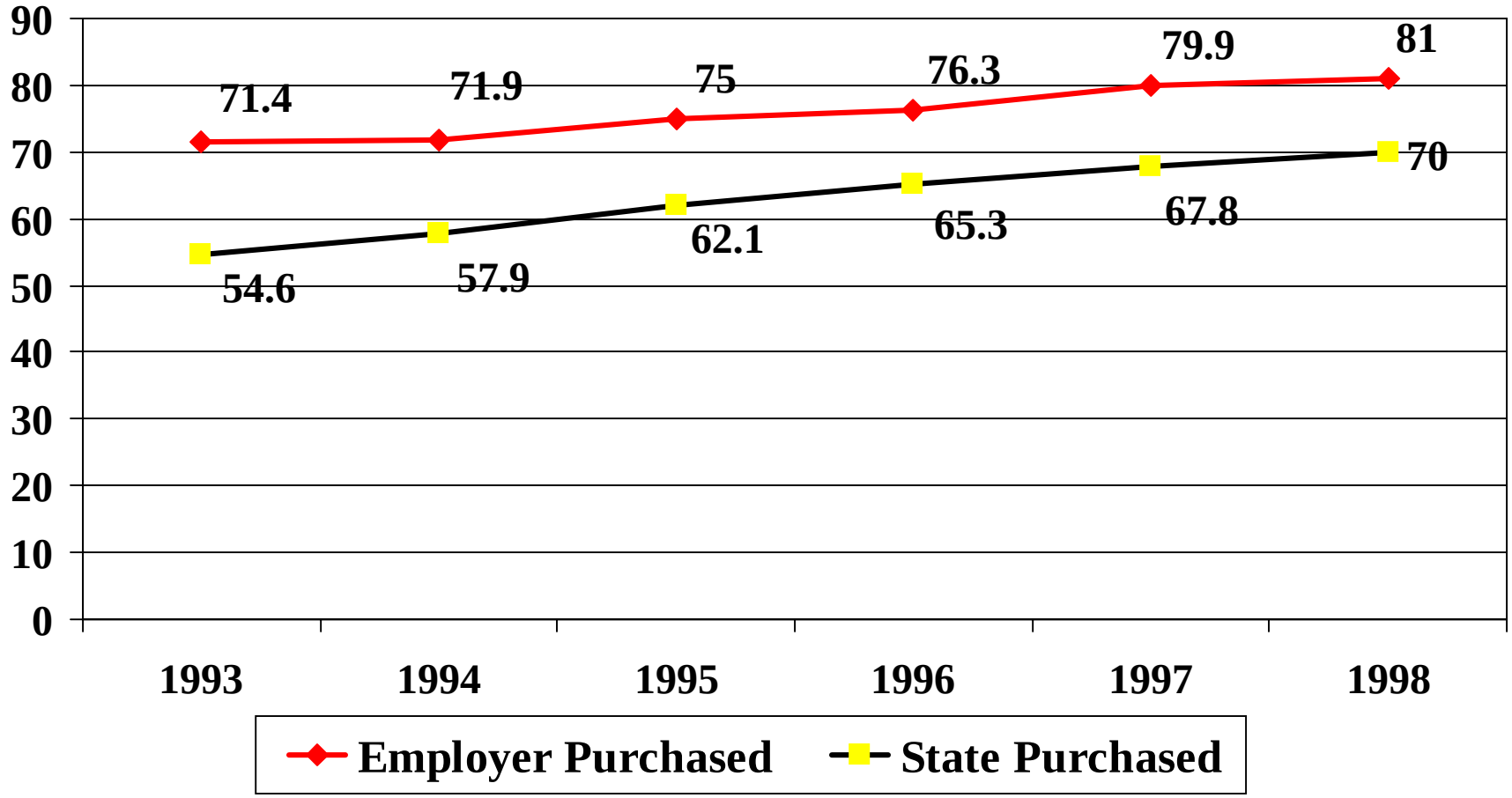
- Managed Care improves access to high quality and appropriate care.
- Low-income and middle-income families use health care the same way.
- Health status will improve dramatically once a person is covered.

Percent Of Women With Short Interval Between Births (<18 Months) by Insurance Status 1993-1998



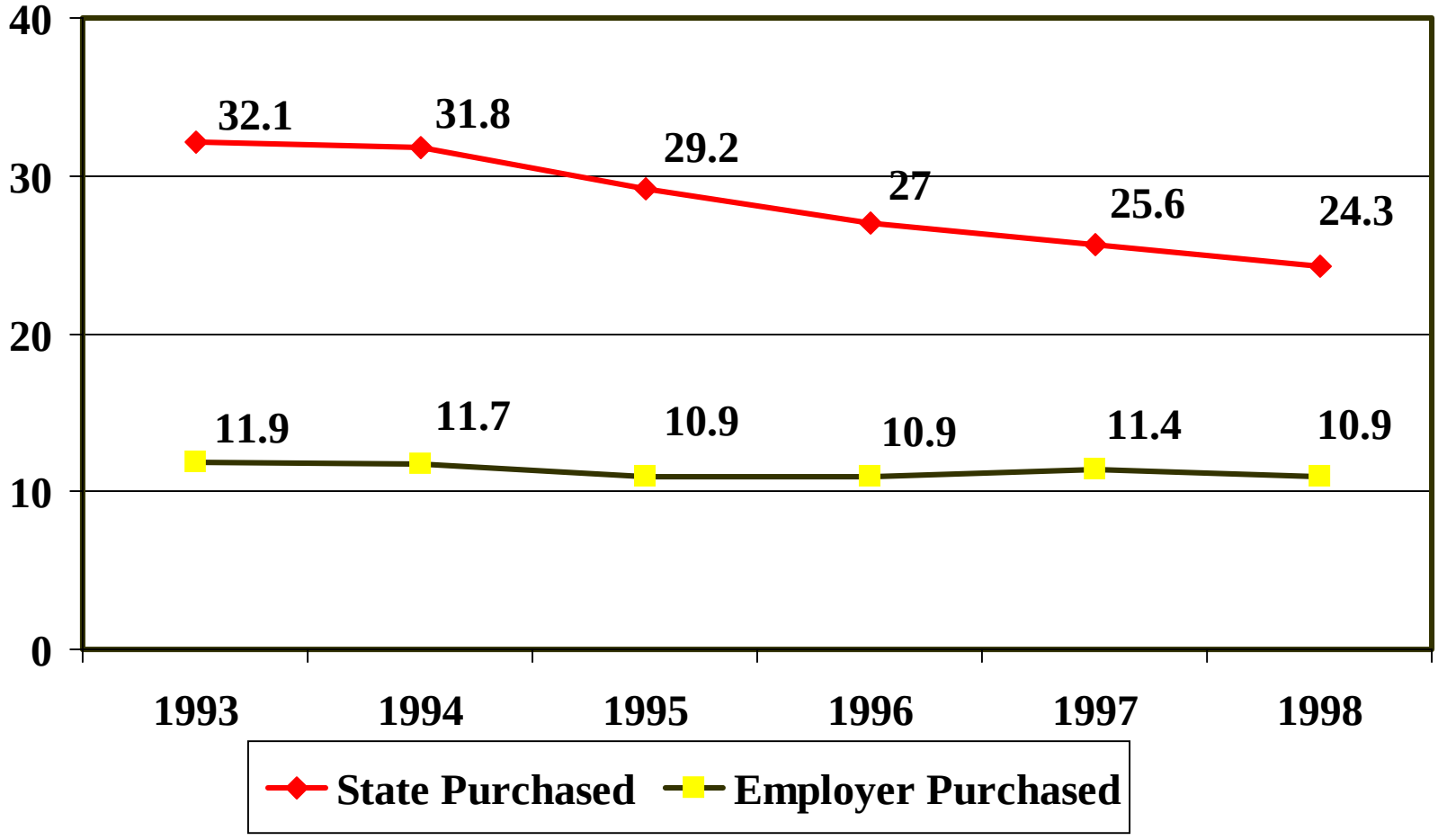
Vital Statistics Birth File-(n=75,642)

Percent of Women with Adequate Prenatal Care by Insurance Status 1993-1998



Vital Statistics Birth File – (n=75,642

Percent of Pregnant Women who Smoke Cigarettes* by Insurance Status 1993 - 1998



Vital Statistics Birth File – (n=75,642) = self-report*

Lessons Learned: Contracting Arrangements

- Risk based capitation using age and gender
- Fixed payment for births (SOBRA)
- Direct payment for Neonatal Intensive Care (NICU)
- Risk share agreement with Health Plan based on medical expenses
- Stop-loss for mental health and substance abuse services, long term care, organ transplant

Lessons Learned: Administration - Budget

- Changing process will affect enrollment.
- Medical Necessity Definition does not cost.
- No day limits for alcohol and substance abuse does not cost.
- Purchasing has to be done with an eye toward capacity – Not everything should be risk based.
- Have to pay plans an adequate rate that is market based.
- Data is essential constant re-evaluations are necessary.
- Adjustment is constant no matter how good your coverage is.
- Market changes will affect enrollment
- HCFA does not have to be the enemy.